National Indian Health Board

Testimony of
Reno Keoni Franklin, Chairman, National Indian Health Board
to the
House Interior Appropriations Subcommittee
regarding
FY2010 Indian Health Service Budget Recommendations

March 26, 2009

Mr. Chairman, and Members of the Subcommittee:

My name is Reno Keoni Franklin. I am a member of the Kashia Band of Pomo Indians in California, and I chair the National Indian Health Board. I also serve as Chairman of the California Rural Indian Health Board, a post I have held for several years and which has enabled me to observe first-hand the many pressing health needs of Indian people. I am here today to give you the National Indian Health Board's views on priorities for the FY 2010 Indian Health Service budget.

SUMMARY OF REQUESTS FOR INDIAN HEALTH SERVICE:

- **Current Services Accounts: +$449.3 million**
- **Program Increases: +$458.7 million**

(Itemized charts are attached.)

NIHB was pleased to learn that the Obama Administration is proposing what is described as a "significant" increase in the Indian Health Service (IHS) budget request for FY2010, to a figure in excess of $4 billion. While we do not yet have any details about the programs and projects for which increases are requested, we are hopeful that the Administration's budget will reflect the recommendations for FY2010 made in March, 2008, by the tribal leaders who comprise the Indian Health Service's National Tribal Budget Workgroup. The Workgroup's detailed recommendations, set out in its paper titled "Restoring the Trust and Leaving a Legacy", were supplied to the Obama Transition Team. NIHB supports and endorses those recommendations and they are attached to my written testimony.

The Workgroup recommended increases in the Indian Health Service Budget totaling $908 million above the expected FY2009 funding levels. These recommendations focus on two types of needed increases:

Current Services Increases are those budget increments needed for the Indian health system to merely continue to operate at its current level of service. This category contains such items as pay cost increases (for IHS, tribal and urban program employees); medical inflation; contract support costs; funding for population growth; facilities construction and staffing; urban program funding (which the Bush Administration sought to eliminate); and restoration of rescission amounts from FY05 and FY06. Without these increases to base funding, we would experience a decrease in our ability to care for our existing service population. The Workgroup recommends an increase of $449.3 million for these items.

Program Services Increases refer to the recommended increases in IHS budget accounts to enable our programs to improve and expand the services they provide to Indian patients. The IHS has long been plagued by woefully inadequate funding in all programmatic areas, a circumstance which has made it impossible to supply Indian people with the level of care they need and deserve. The Workgroup recommended $458.7 million be added to identified program and facilities accounts.

Budget Management Issues. I want to mention three issues involved with budget management which deserve special attention from the Subcommittee.

First, it has been OMB's practice for the past several years to apply the non-medical inflation factor to the IHS budget. This is wrong, as it greatly underestimates the amount needed to keep up with inflation. Instead, the medical inflation factor should be applied to the IHS budget to more correctly reflect the increased amount needed for a system that is responsible for providing direct care to patients and for purchasing care from public and private providers through the Contract Health Services program. Using the non-medical inflation factor is a sleight-of-hand way of depressing the budget and understating the system's true need. For Congress to make informed appropriation decisions, it needs to have accurate estimates of the amount needed to cover inflation in medical care costs.

Thus, we ask that Appropriations Committee to instruct IHS budget developers and OMB to apply the medical inflation rate to all subsequent IHS budget requests.

Second, the IHS budget must be shielded from Administration rescissions and Congressional across-the-board cuts. Our system provides direct care to patients. It is unfair – and inhumane – to make IHS programs vulnerable to budget devices employed for the sole purpose of achieving arbitrary budget ceilings. It would be difficult enough to absorb such reductions if the IHS system were funded at its true level of need. But where, as here, our system is funded at 60% of need at best, arbitrary, un-planned for, cuts to program funding put prudent patient care at severe risk.

Thus, NIHB asks for bill language that would protect the IHS budget from all rescissions and across-the-board cuts imposed by the Administration or Congress.

Third, the myriad of Indian programs throughout the Federal Government need better coordination, especially with regard to budget development. This is why NIHB, along with the National Congress of American Indians, has recommended that the Obama Administration

appoint an Indian programs liaison officer at each Federal agency – including the Office of Management and Budget. Ideally, the OMB liaison officer would be located in the Office of the Director and be charged with gathering in one place information about Indian Country needs, and advising the Director on how to more effectively and efficiently coordinate Indian programs within and between Federal agencies.

For example, programs to combat alcohol and substance abuse in Indian Country involve at least four agencies – the Indian Health Service, the Bureau of Indian Affairs, the Department of Education and the Substance Abuse and Mental Health Administration. Coordinating agency agendas and budgets for programs with similar objectives could help reduce duplicative paperwork requirements and better target services to intended beneficiaries.

NIHB asks the Appropriations Committee to encourage OMB Director Orszag to create a new position in his Office to coordinate budget policy for Indian programs.

Specific Indian Health Programs. In the time remaining, I want to mention a few programs identified by the IHS Tribal Workgroup for vital programmatic increases and tell you why I believe you should support these recommendations.

- **Contract Health Services**. This Subcommittee is well aware of the CHS program's critical role in providing health care to Indian people. The CHS program exists because the IHS system is not capable of supplying directly all the care needed by our service population. In theory, CHS should be an effective and efficient way to purchase needed care – especially specialty care – which Indian health facilities are not equipped to provide or which are not cost-effective to offer at every location. But the reality is that the gross underfunding of CHS means that we cannot purchase the quantity and types of care needed. Thus, too many of Indian people are left with un-treated and often painful conditions which, if addressed in a timely way would improve quality of life and cost less to treat. Instead, these conditions are allowed to worsen over time until they become life- or limb-threatening and the care required is far more expensive.

  The Workgroup proposed what I believe is a very modest $110 million increase for CHS, although by many estimates the program should be increased by more than $300 million annually. I urge you to provide a more humane level of funding for the CHS program.

- **Contract Support Costs.** I just cannot understand why Indian Country must constantly implore Presidents and Congress to fully funding contract support costs. Since 1975, when the Indian Self-Determination and Education Assistance Act became a cornerstone of Federal Indian policy, Indian tribes have, in good faith, sought to carry out this policy by exercising the right that law provides to take over direct operation of IHS programs. Yet, by refusing to properly fund CSC, the Federal Government actually impedes its own policy and forces tribes to divert health care dollars to cover the contracting costs we incur. NIHB supports the Workgroup's recommendation that the CSC line item be increased by $143.3 million for FY2010, and that all subsequent budgets provide full funding for these costs.

- **Hospitals and Clinics.** This is the core account which funds our system's medical care programs. It also includes funding for the Indian Health Care Improvement Fund (IHCIF) which provides separate funding for distribution to selected operating units in order to reduce resource disparities between units within the IHS system. Without an appropriate level of support in the Hospitals and Clinics account, the United States' trust responsibility for Indian health cannot be met and IHS is unable to fulfill its health care mission. We urge you to accept the Workgroup's recommendations to increase the overall Hospitals and Clinics account by $107.4 million, and to supply an additional $61.2 million for the IHCIF.

- **Healthcare Facilities and Sanitation Facilities.** We call to the panel's attention the Workgroup's recommended increases in various facilities-related accounts – Healthcare Facilities construction (+$93.5 million); maintenance and improvement (+$8.1 million); Sanitation Facilities construction (+$26.2 million); and facilities and environmental health support (+$4.1 million). You know as well as I do that many, many of our health care facilities are inadequate and in poor repair. Funding for new construction had been on a "pause" under the prior Administration, and maintenance and improvement funding has been insufficient to meet demand.

  We are grateful for the generous funding for healthcare and sanitation facilities construction and maintenance provided in the American Recovery and Reinvestment Act, as it will help make up some of the ground lost over the past several years. This is only a one-time boost in resources, however. We need the Obama Administration and the Congress to commit to provide more appropriate levels of support for these facilities accounts – and to do so on a *continuing, recurring basis*.

On behalf of the National Indian Health Board, I thank you for the opportunity to address the Subcommittee on these important matters. I am happy to answer your questions.

Recommendations of Indian Health Service National Tribal Budget Workgroup

FY 2010 CURRENT SERVICES INCREASES	
Pay Costs	$ 47,730,000
Inflation	51,038,000
Additional Medical Inflation	36,349,000
Contract Support Cost	143,259,073
Population Growth	22,544,792
Health Care Facilities Construction	93,556,187
Staffing New/Replaced Facilities	15,118,568
Restore Urban Programs	35,000,000
Restore FY 2005 Rescission	3,500,000
Restore FY 2006 Rescission	1,250,000
TOTAL CURRENT SERVICES	**$ 449,345,620**

FY 2010 PROGRAM SERVICES INCREASES	
Health Accounts	
Hospitals & Clinics	$107,391,447
Indian Health Care Improvement Fund (subset of H&C)	61,205,765
Information Technology (subset of H&C)	4,927,850
Dental	17,266,383
Mental Health	23,592,385
Alcohol and Substance Abuse	32,561,359
Contract Health Services	109,833,578
Public Health Nursing	7,895,049
Health Education	4,392,135
Community Health Representatives	8,102,018
Alaska Immunization	54,927
Urban Indian Health	3,121,335
Indian Health Professions	1,555,099
Tribal Management	4,976,344
Direct Operations	622,357
Self-Governance	142,068
Facilities	
Maintenance & Improvement	8,103,413
Sanitation Facilities Construction	26,195,488
Facilities & Environmental Health Support	4,169,464
Equipment	1,690,656
HFC Priority System Area Distribution*	20,000,000
Other Priority Recommendations	
Ambulatory/Outpatient	5,671,807
Pharmacy	1,250,000
Diabetes	3,151,004
Injury Prevention	833,333
TOTAL PROGAM INCREASES	**$458,705,264**
* The ADF funding methodology is currently under review by the IHS and HHS.	